

ABSTRACTS/SUMMARIES OF PAPERS PRESENTED AT
TAXES AND HEALTH INSURANCE: ANALYSIS AND POLICY

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Tax Policy and the History of the Health Insurance Industry

Robert Helms

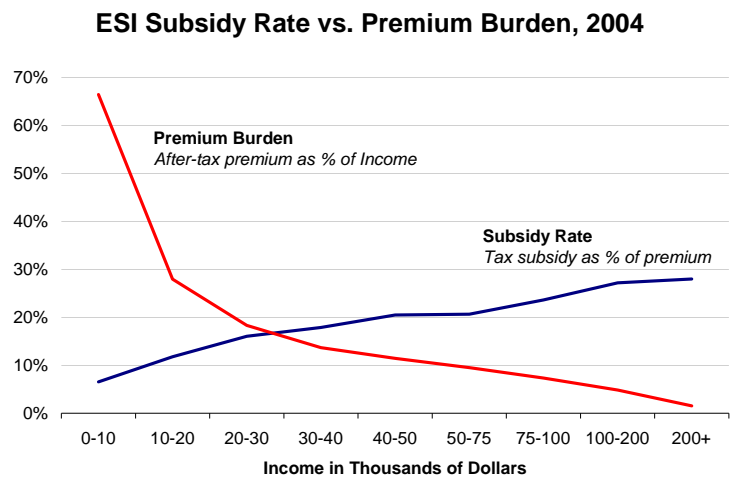
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This paper provides a brief sketch of the historical development of the health insurance industry as we know it today. Using World War II as a convenient dividing line, it explores economic, medical, and policy developments before, during, and after the war with special emphasis placed on the role of tax policy. The paper also reviews some key economic studies that have attempted to measure the effects of tax policy and the conclusions the authors reach. After a discussion of economic, legal, and medical definitions of inefficiency, the main conclusion offered is that reform of tax policy is a necessary condition for the efficient reform of our health care system.

The Tax Code, Health Insurance Coverage, and Utilization
Leonard Burman, Bowen Garrett, and Surachai Khitatrakun
The Urban Institute/Tax Policy Center

Although many markets would work best without government interference, the market for health insurance is probably not one of them. The market for health insurance is affected by almost every market failure imaginable. The main government intervention for working age Americans and their families is the exclusion from income and payroll taxes of employer contributions for employer-sponsored insurance, which reduces income and payroll tax revenues by \$200 billion or more per year.

In one sense, it has clearly been a success. More than two-thirds of Americans under age 65 get their insurance at work. Large employers can offer insurance at relatively low cost, and almost all do. However, the employer group works less well for small firms. And the tax exclusion is poorly targeted. Low-income workers can face health insurance premiums equal to 30 percent of their incomes, but the income tax subsidy is worth little or nothing to them and they are disproportionately likely to lack insurance. High-income people, for whom insurance would be affordable and desirable even absent a subsidy, receive the largest share of the tax benefits. Also, the open-ended subsidy provides an incentive to get overly generous insurance with few controls on spending.



Eliminating the subsidy, without providing a better-targeted alternative, would surely reduce the number of people with health insurance. Estimates suggest that the number of firms offering insurance would decline by more than 15 percent, concentrated among small and medium-sized firms. The people most likely to lack insurance would be those with poor health status—for whom nongroup insurance is unavailable or unaffordable—and those with low incomes. While it is possible that the health insurance market would find new ways to pool insurance among those who no longer get it at work, it is also possible that some large firms would drop coverage if the after-tax cost of insurance increased dramatically.

This paper summarizes the various tax subsidies for health insurance, examines the arguments for government intervention in the health insurance market, and focuses on the likely economic effects of the large subsidy for ESI. We analyze how the tax subsidies for employer-sponsored insurance are distributed and evaluate evidence on how the ESI exclusion affects health insurance spending and coverage.

Simple Humans, Complex Insurance, Subtle Subsidies

Jeffrey Liebman and Richard Zeckhauser
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The behavioral revolution in economics tells us that human beings often have a difficult time making wise choices. The most widely chronicled difficulties occur in conjunction with decisions made under conditions of uncertainty, decisions that involve significant elements of time, and decisions in complex environments. Unfortunately, these are precisely the types of choices that are entailed when individuals must choose a health insurance policy or decide whether to consume health care. In this paper, we argue that a sound policy analysis of the tradeoffs involved in giving consumers increased responsibility for making health care choices must supplement traditional economic models of insurance with critical lessons from behavioral economics. Indeed, we argue that behavioral economics provides much more of a normative justification for many of the features of our existing health care policies than do the prime models of traditional economics. If our argument is accepted, the logical implication is that many current policies are mis-designed, given that their justifications are not understood. Our analysis has four implications for health care reform:

1. *Consumers Need to Have Their Health Insurance Purchases Mediated.* Health insurance is too complicated a product for most consumers to purchase intelligently. The employer-based system, though not without its drawbacks, works well because employers have strong incentives to act as faithful agents for their employees. In that role, they usually select a very limited number of carefully screened health insurance options.

2. *Copayments and Subsidies Should be Designed Via Cost-Effectiveness Analysis*

Many reform proposals appear to be guided by the goal of having consumers come as close as possible to facing the social price of producing care. Our analysis suggests that this is the wrong benchmark. Most humans do not act as fully-informed, rational individuals who understand probabilities, are exponential discounters, and choose in their own self interest. Therefore, insurance subsidies and copayment rates should be set to maximize a cost-effectiveness measure of health outcomes relative to dollars spent, rather than set to approximate the social cost of producing care. A corollary is that not all therapies, office visits, and interventions should be priced equally. Subsidies should be targeted at highly cost-effective treatments.

3. *Efforts to Cover the Uninsured Should Reflect Behavioral Obstacles to Coverage*

The standard model of the uninsured envisions those individuals as crafty calculators who have figured out that insurance is costly to them because they are in a risk pool that charges more than their expected cost, and because the benefits of insurance are truncated by the option of falling back on uncompensated care should they experience a medical emergency. Our analysis of behavioral propensities suggests that uninsurance may result more from inertia, complexity and status quo bias than from shrewd financial calculation. If we are right, efforts to expand insurance coverage should focus more on finding ways to automatically enroll people into a default health insurance plan than on punitive financial incentives.

4. *Information Gathering on Effects of Behavioral Interventions Should be Increased*

One implication of individuals' deficiencies in making good decisions on their own is that someone else must help make those decisions that are both complex and important. This places an extraordinary information burden on the mediators charged with setting up default insurance plans and determining the subsidy and copay levels within them.

Tax Subsidies for Out-of-Pocket Healthcare Costs

Jessica Vistnes*, William Jack+, and Arik Levinson+

Tax subsidies for out-of-pocket healthcare expenses have existed in various forms in the U.S. for almost three decades. Given a subsidy, insurance purchasers may opt for plans with lower premiums and higher out-of-pocket costs, knowing that these uncovered expenses will be subsidized.

In this paper, we focus on FSAs, a 1978 policy that allows employees to set aside pre-tax income to pay for their out-of-pocket healthcare expenses. We ask whether workers with access to FSAs are offered and enroll in health insurance plans with greater out-of-pocket costs. In particular, we examine the degree to which the availability of FSAs has affected the coinsurance and copayment rates for physician office visits and the level of overall deductibles.

Our evidence is mixed. In the aggregate, as more establishments offer FSAs, and more workers have access to them, coinsurance rates for employees with access to FSAs have been falling relative to rates for employees without FSAs, and copayments and deductibles have been rising more slowly.

When we control for other plan and establishment characteristics, and attempt to control for the simultaneous decision by firms to offer FSAs, we do find some evidence that coinsurance rates are higher in establishments with FSAs, but no similar evidence for copayments or deductibles. Overall, our preliminary results do not provide much evidence in support of the hypothesis that tax subsidies have large effects on out-of-pocket costs.

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The Effect of Tax Preferences on Health Spending

John Cogan*, R. Glenn Hubbard+, and Daniel P. Kessler—

In this paper, we estimate the effect of the tax preference for insurance on health spending based on the Medical Expenditure Panel Surveys from 1996-2005. We use the fact that Social Security taxes are only levied on earnings below a statutory threshold to identify the tax preference's impact. Because employer-sponsored health insurance premiums are excluded from Social Security payroll taxes, workers who earn just below the Social Security tax threshold receive a larger tax preference for health insurance than workers who earn just above it. We find a significant effect of the tax preference, consistent with previous research.

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Reforming the Tax Treatment of Health Care: Right Ways and Wrong Ways

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Health care in America faces three fundamental problems: tens of millions uninsured, high level of spending by insured with little benefit at the margin, and a long-run fiscal gap. An ideal reform proposal would make progress in some or all dimensions simultaneously. A potentially acceptable proposal would make a tradeoff between these three goals. Moving in the wrong direction in some or all dimensions – without any progress in others – should be unacceptable.

This paper uses these three criteria to evaluate two reform options that are found wanting. The first is the proposal by John Cogan, Glenn Hubbard, and Daniel Kessler (2005) to make all health expenses tax deductible. The second is the proposal to make all individual market premiums tax deductible. Both of these proposals share the common features that they provide new tax subsidies in the service of reforms that have uncertain benefits and could even be counterproductive. Although there are numerous other health-tax reforms, the shortcomings of these plans provide a cautionary note for many of them. This discussion motivates the considerations in designing a plan to replace the existing tax exclusion in a manner that would increase coverage, reduce costs and help (or at least not hurt) the long-run fiscal gap. The proposal would combine progressive, refundable tax credits with three sets of reforms to insurance markets: (1) a mandate or other institutional mechanisms like automatic enrollment; (2) new pooling mechanisms like the Connector in Massachusetts, and (3) ways to reduce adverse selection in existing pooling mechanisms through techniques like catastrophic reinsurance.

Administrative Issues I: Challenges of the Current System

Mary B. H. Hevener* and Charles K. “Chip” Kerby III+

This presentation (by two tax attorneys whose practice area focus for 30 years has been on health plans, employee compensation tax issues, and information reporting) addresses complexities of the existing tax incentives (and tax limitations) on employer-provided and individually purchased health care, as well as many tax law provisions that currently permit employers to exclude workers from coverage, and systemic problems that have contributed to prior failures to limit excessive or discriminatory compensation arrangements.

Specific topics that will be covered are:

- Basics of the rules governing the tax treatment of employer-provided and individually purchased health coverage;
- Survey of the alphabet-soup of types of health care plans (FSA, HSA, HCTC, COBRA, MSP rules, and “working condition fringes”);
- The minimal information reporting requirements currently applicable to health coverage to the IRS (or any other data-collectors);
- The vague and minimally enforced nondiscrimination rules applicable to self-insured health plans and cafeteria plans;
- The ability to exclude leased employees (as well as persons under 25, part-time employees, and union workers);
- The limitations on the IRS’s ability to challenge the classification of workers as “independent contractors” (ineligible for employee coverage), as opposed to “employees”;
- Historic failures of attempts to control discriminatory or excessive compensation through codified tax penalties (including not only the “Section 89” debacle in 1986-88, but also penalties on “golden parachutes,” excessive executive compensation, nonqualified deferred compensation, and “lavish” expenses);
- Administrative problems under the current system that will complicate enactment of either employer mandates, individual mandates, or various incentive proposals;
- Suggestions for changes in the current system’s information reporting and withholding rules to accommodate various health reform proposals; and
- Suggestions for dealing with systemic delays in issuing implementing regulations and rulings, and with conducting audits to prevent noncompliance.

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+ McDermott Will & Emery

The Challenges of Implementing Health Reform through the Tax System

**Janet Holtzblatt
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Fundamental health reform plans often envision a key role for the Internal Revenue Service (IRS). Health reform proposals may cap or eliminate the current exclusion for employer-provided health insurance, create new tax-based subsidies for health insurance, and use the IRS to enforce individual or employer mandates. Since 2007, Massachusetts's Department of Revenue has been enforcing a mandate requiring individuals to obtain health insurance coverage, although other components of the state's health reform are administered by other agencies.

The IRS faces three major challenges in implementing health reform. The first is whether the tax system can reach the targeted population without substantially increasing compliance burdens or administrative costs. The second is whether the IRS can enforce either a mandate or eligibility rules for a subsidy, without causing noncompliance to increase or participation in subsidies – or more broadly the tax system – to fall. The third – and perhaps most difficult challenge – is whether the IRS can enforce mandates or pay out subsidies during the tax year, given the annual accounting structure of the income tax.

Simplifying the criteria used to target subsidies or exemptions from the mandate would facilitate implementation of health reform through the tax system. In addition, investments in new information and computing systems may be necessary to facilitate the flow and processing of data, eligibility determination, and payments. However, the IRS will likely need time to identify problem areas, absorb new data, determine how best to use available information, and obtain sufficient resources and authority to tackle problems. Verification of eligibility for subsidies or compliance with mandates may fall short of desired goals, at least in the short-term, and policymakers may need to make trade-offs between various tax and health policy goals in the interim.

These challenges are not unique to the income tax system. Other agencies would also face similar challenges if asked to implement all or some portion of health reform. For policymakers, the decision between the IRS and another agency to administer health reform must address two questions: first, which agency can assimilate new responsibilities at minimal cost; and second, which trade-offs are acceptable if all objectives cannot be achieved.

Health Savings Accounts I: Short- and Long-term Effects of Health Savings Accounts

**Lisa Clemans-Cope
The Urban Institute**

This paper examines the introduction of health savings accounts (HSAs), and their potential to expand insurance coverage and constrain health spending growth through enrollment in HSA-qualifying high-deductible health plans (HDHP/HSAs). First, the paper presents the most recent data reflecting offer, enrollment, premiums, cost sharing, and cost-containment for HDHP/HSAs in the group and non-group markets. Among firms that offer health insurance, only a small share offer a HSA-qualifying HDHP, and the share did not increase between 2006 and 2007. Rates of take-up in these new plans in both the group and non-group markets have been relatively modest. Data presented show that the impact of cost sharing on cost-containment is limited by the distribution of health expenditures. The vast majority of health care expenditures are associated with spending that exceeds even the high deductibles associated with HSA-qualified HDHPs.

Second, the paper examines effective marginal tax rates for individuals by health insurance status, and estimates the tax advantages for uninsured singles and families if they were to gain coverage through a HDHP/HSA. However, whether or not the estimated tax advantages of HDHP/HSAs can generate savings relative to more comprehensive plans for some individuals depends on whether increases in out-of-pocket spending under the HDHP are offset by tax savings and decreases in premium payments. This question will be addressed in future research.

Third, the paper investigates the potential for adverse selection in the group market if healthier individuals take-up coverage in HDHP/HSAs in either the group or non-group market. In the long run, policymakers considering strategies to further increase enrollment in HDHP/HSAs must weigh the problems of risk selection and adverse health outcomes from underutilization of cost-effective health services in response to increased cost sharing against the gains in cost-containment.

WHAT'S IN A NAME?

ARE HEALTH SAVINGS ACCOUNTS REALLY HEALTH SAVINGS ACCOUNTS?

Henry J. Aaron,* Patrick Healy,* and Surachai Khitatrakun⁺

Health savings accounts were authorized by legislation enacted in 2003. They are intended to encourage enrollment in high deductible health insurance. They are widely viewed as a significant element of health care policy in their own right. This view is an error. HSAs are instead the most highly tax-favored form of retirement saving. As such, rational nonelderly savers should nearly forebear from spending HSA balances on health care or anything else and use current income or funds drawn from other assets in order to pay for health care.

This paper first presents the philosophical, economic, and historical background of HSAs. It then turns to an explanation of why HSAs should be regarded as a retirement saving instrument, not as a *health* account. To put the same point another way, HSAs are carrots to attract people to high deductible insurance, which means that nearly all of the impact on health care spending by rational non-elderly account holders derives from the high-deductible insurance and virtually none from the HSAs themselves. The common perception that HSAs should have some direct impact on health care spending is incorrect.

Of course, not all account holders are rational decision makers, which means that HSAs may influence health care spending. This possibility is heightened by the very name of the account which links HSAs lexically to health. The irrationality is illustrated by the failure of people to enroll in high-deductible plans linked to HSAs even when such enrollment is clearly advantageous. We report the experience of one medium-sized company with such plans. The company offered employees the chance to enroll in a high-deductible plan and an HSA to which the company made deposits. The network of providers was the same as under the company's traditional PPO. Under the terms of the two plans, an employee would be financially better off at all possible levels of health care spending under the high-deductible/HSA combination than under the PPO. However, only about one-fourth of those eligible to make the switch from the PPO actually did so.

This finding raises the question of why workers are hesitant to accept high-deductible insurance linked to HSAs. We suggest several possible reasons: status-quo bias, political reservations about high-deductible insurance; added record keeping under high-deductible plans; and misinformation. This behavior also raises the question of whether HSAs are the best 'carrot' to encourage adoption of high-deductible insurance, particularly since HSAs are indefensible as tax policy. We speculate that other less regressive incentives might hold greater attractions for enrollees. To the extent that people use hyperbolic discounting or high discount rates, the incentive to buy high-deductible insurance of front-loaded or lump-sum inducements through grants or refundable tax credits might be greater than are those of HSAs, a large part of the benefits of which are deferred.

In the final version of this paper, we hope to use the Urban/Brookings Tax model to analyze the impact of HSAs on insurance choice and of the induced purchase of high-deductible insurance on health care spending.

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